Alabama Department of Senior Services Medicaid Waivers Case Management Guide

August 2014

Table of Contents

ADSS MEDICAID WAIVER PROGRAMS

CASE MANAGEMENT GUIDE

ADMINISTRATION

The Centers for Medicare and Medicaid Services (CMS) grants the State of Alabama approval to provide Home and Community Based Services (HCBS) under Title XIX of the Older Americans Act.

The Alabama Medicaid Agency (AMA) designates the Alabama Department of Senior Services (ADSS) as the Operating Agency for the Elderly and Disabled (E&D) and HIV/AIDS (530) Waiver programs.

ADSS contracts with 13 Area Agencies on Aging (AAA's), Councils of Local Governments (COG's) and/or Regional Planning Commissions (RPC's) to provide case management and perform the local activities necessary to fulfill the objectives of the programs.

PURPOSE

The purpose of these programs is to serve the Medicaid eligible who require nursing home care and are at risk of nursing home placement. The basis of these programs is founded on two reasons:

- The cost of this program VS nursing home cost.
- The desire of the client to remain in their own home for as long as possible.

CASE MANAGEMENT

QUALIFICATIONS

Case management will be provided by a professional, having earned a Bachelor of Arts or a Bachelor of Science degree, preferably, in a human services related field, from an accredited college or university, or having earned a degree from an accredited school of Social Work or, a Registered Nurse with current licensure.

In addition, the professional is trained in the Case Management curriculum currently approved by the Alabama Medicaid Agency. The case manager must have references which will be verified and documented in the personnel file. References must include statewide criminal background checks, previous employers, and the Nurse Aide

Registry if applicable. All case managers must meet required training requirements per ADSS and AMA guidelines.

CASE LOAD

The full time case manager should maintain a caseload of 35-40 clients depending upon factors such as the geographic area to be covered, additional responsibilities and individual differences in the case manager's work habits.

GOALS

The goal of the case manager is to enable a chronically impaired person to remain in or return to the most desirable and least restrictive environment, while maintaining the greatest amount of independence and human dignity, in a cost efficient manner.

KEY NOTES

- Case management is commonly understood to be a system under which the responsibility for locating, coordinating and monitoring a group of services rests with a designated person or organization.

- Case management is a management and administrative service that assists clients in obtaining services.

- Case managers are responsible for assuring that services are provided appropriately and modified in response to changes in the client's condition.

- Case management is individualized. Each client is treated as an individual.

- Case management is both a direct and indirect service. This includes face-to-face contact with individual clients, families, neighbors and physicians. A case manager may have to go behind the scenes to establish community resources such as church support and community centers to assist with electric bills, meals, medications, etc.

PROCESS

Case management is the process of:

- ASSESSMENT - assessing a person's physical, environmental, financial, cognitive and functional level.

- IDENTIFY - identifying what needs and problems are present.

- DETERMINE - determining what services are needed to enhance the current support system, if any.

- PLAN - planning for those services.
- LOCATE - locating, developing, arranging and coordinating those services.
- MONITOR - monitoring the provision of those services, as well as changes in the recipient's condition.
- ADJUST - adjusting the service plan as needed.

ACTIVITIES OF CASE MANAGEMENT

OUTREACH

Outreach is the process of creating awareness in the professional community and in the general public of the availability of services in order to identify and establish contact with those who are appropriate for the waiver programs.

REFERRAL

Referral is the process through which the person's in the community in need of waiver services are referred to the program.

PRE-SCREENING

Pre-screening is the process through which the person's need for case management is evaluated and eligibility is verified.

- ✓ Financial eligibility is verified.
- ✓ Effective pre-screening allows the case manager to utilize his/her time and resources on cases with a greater possibility of approval, therefore; the case manager must distinguish between those in need and those at risk of nursing home placement.
- ✓ Pre-screening can be accomplished over the telephone; however, if the case manager doubts the validity of the answers, a home visit is appropriate.
- ✓ Pre-screening is to make the client aware of the program, its benefits and its limitations. Family responsibility needs to be outlined carefully in this phase, as well as the reasons that the in-home care could be terminated.

ASSESSMENT

The assessment is the process by which the health, functional level, social needs, psychological, cognitive, financial needs, environmental and support needs of a client is

identified utilizing a structured assessment instrument. The assessment is an ongoing process due to the changes that take place in the life of the client.

The assessment process highlights:

- ✓ Weakness
- ✓ Support systems
- ✓ Strengths
- ✓ Client's needs and demands
- ✓ Client's lack of capacity to meet demands

Other data should be gathered such as:

- ✓ Existing conditions
- ✓ Gaps in existing conditions/services
- ✓ Uniqueness of the individual
- ✓ Observation concerning the reliability of the client's responses
- ✓ Any signs of dementia/impaired judgment
- ✓ Communication limitation
- ✓ Any fear of answering questions

Having made the above determinations, the case manager can begin to plan how to meet the needs and modify the demands or increase the capacities for meeting the demands. This is done via the care plan.

CARE PLAN

The Care Plan is a statement of goals to meet client's needs and identification of services necessary to achieve those goals.

Care planning is the link between the assessment and the delivery of services; it is the action taken to address identified problems. Care plans should be updated when a change is made in the service.

Case managers are expected to:

- ✓ Develop a clear and factual care plan for each client based on individual needs that addresses night and day, weekday and weekend requirements. Careful consideration should be given to all service alternatives before any decisions are made regarding what is best for the client.

- ✓ Maintain a listing of service agencies, organizations, the services provided by each, and eligibility requirements for those services and the contact person to aid in the care planning process.

- ✓ Develop specific goals for the client.

- ✓ Use beginning and ending dates appropriately on the care plan.

This form must be completed fully, signed by the client, and the original must be kept in the case file, a copy placed in the in-home file and another copy given to the DSP at both the initial client assessment and all redeterminations.

- ❖ All waiver and non-waiver services must be listed on Care Plan.

- ❖ Under the frequency column, indicate the amount and number of times the service is provided. Be specific, for example: “2xwk 3hrs” not “6hrs wk” or “up to 6hrs wk”. Do not use the names of the days of the week as they may change. For the frozen meals services use “1xwk, 1 or 2 unit(s) wk”

- ❖ Services listed on the Care Plan must be based upon the diagnoses stated on the Medical Form. ADSS/AMA/CMS will not approve services that do not appear to be needed to maintain the client in the community.

- ❖ If a client requires a service that is not currently available, it is the responsibility of the case manager to indicate this need on the plan of care. Omission of such information may place the client at risk by jeopardizing health and safety.

- ❖ Respite care must be labeled as unskilled or skilled. These are two separate services, not variations of one. Remember the limitations of this service.

- ❖ The items on a care plan must match those billed. For example, if personal care has not been approved as part of the care plan, Medicaid will not accept billing for these services. This includes the amount of, as well as the type of, services.

- ❖ If a family member has been trained to provide services and the presence of a LPN is not necessary, documentation of this fact should be included in the medical form and care plan.

- ❖ Medicaid will not pay for routine visits to the doctor and, therefore, will not pay for completion of the ADSS ASSESSMENT FORM. If the physician requires payment and bills the AAA/COG/RPC, this cost may be reimbursed as a case management expense.

- ❖ Any application received by ADSS that does not contain these completed documents with the required signatures will be returned as an incomplete application.

- ❖ NEVER **DELETE** AN ENTRY IN AIMS. This is your history of the clients care. Put an end date for the entry and create a new entry for other services

needed.

PAPER APPLICATIONS: These, for the most part, are no longer used with the exception of “Deeming Cases”; however, most of the following rules still apply to the electronic applications. When a change is made in a service, end that service by writing in an ending date on the care plan. To begin a new service, write the beginning date and the service to be provided. All entries must have a begin date. If the exact start date is unknown, the start month and year will be acceptable. **Do not scratch out, black out or white out services no longer in use. Use beginning or ending dates to form a history of the client’s care.**

ELECTRONIC APPLICATIONS: Make a copy of the application that is transmitted electronically and keep it in the case file to be used as a working copy. Make all changes and corrections on the paper copy of the care plan while in the field and away from your computer. Once all corrections are done in AIMS, a new clean copy can be printed for the clients’ record. AIMS will not allow you to delete an entry on the care plan once it is saved. If an entry is noted to be incorrectly updated in AIMS, enter an end date, make any appropriate Case Manager notes and update the correct information.

A care plan should reflect ALL assistance and services received by the client. This includes services provided under the waiver programs and other non-waiver services such as hospice, home health, personal care under Medicaid, informal support by family, friends, civic or church groups, as well as doctor visits and all non-paid services by agencies or organizations,

The type and amount of care should relate to goals. If the goal is to maximize self-care, the case manager will assure that a limited number of services are provided without jeopardizing the client’s safety. If the goal is to strengthen the care of the family, the amount of assistance should vary to fill in the identified gaps.

Waiver services may not exceed the statewide average cost for the same level of care in a nursing home. In some cases, a client may require services that exceed the statewide average cost of institutional care; these cases should be monitored closely to ensure community services are appropriate and that the client’s health and safety are protected.

The client/identified caregiver should be involved in the care planning process (as they may be the best source of information about what their needs are). These decisions include type, frequency and duration of services. And they must understand that services provided on the care plan are not designed to replace, but to supplement his/her efforts.

SERVICE COORDINATION

Service coordination is a process that is accomplished by the case manager, along with input from the client/caregiver and other involved agencies/parties.

This process should flow from the information gathered at the assessment and reflect the total picture of the client's situation.

The case manager should take into account the individual characteristics of a client, the primary caregiver and the community in the selection of a care provider.

The case manager should contact the formal and informal providers to ascertain their availability. Do not take for granted that the resources/services existing before other services were added will remain in the home and at the current service level.

ASSESSMENT FORM

ADSS HCBS

- These pages **must** be completed fully and transmitted via AIMS as a part of the application process. A copy of the completed form will be kept in the case file, and another given to the DSP at both the initial client assessment and all redeterminations.

- The "Initial Assessment "is for a client not yet on the waiver. **Do not** place a date in the "Date Eligibility Expires" field, this is for redeterminations.

- Pay careful attention to the ADL's section. This will be used to determine the plan of care and help with the medical determination. Be sure to list who is providing the assistance and include a telephone number for that person.

- Be sure everything on the form supports the Care Plan and the Medical Form.

- The comment section should be used to document additional information that supports the clients need for waiver services. **Do not** repeat information listed elsewhere on the application (i.e.: medical diagnosis). This section should be used for supporting documentation and information needed to make the medical determination. (Example: why two workers are needed in the home to perform personal care, why a PC worker is going into the home twice a day or why a client is "too tired" to clean their own home or give themselves a bath).

MEDICAL FORM

- This form **must** be completed fully and the **original** must be kept in the client record. A copy must be given to the DSP at both the initial client assessment and all redeterminations.

- This form requires an **original** signature by both the physician and two

signatures by the client. Each signature and date must be in the same ink (electronic signatures may be used), indicating they were signed at the same time. Rubber stamps, white out, stickers, signatures by the physicians' nurse, Nurse Practitioners (*a Nurse Practitioner is not a Physician*) or any other person other than the clients' physician is **not acceptable.** This information will not be seen by the nurse making the medical determinations so it up the Case Managers to insure this information is done correctly. The form will be randomly audited and could be the cause of recoupment of funds if found not in compliance with Federal Regulations.

All Initial Applications, Readmissions, Redeterminations and Reinstatements **must** have two (2) or more criteria checked for admission to the waiver program.

ADMISSION CRITERIA

(Check all that the resident requires on a regular basis: Resident must meet at least two of the A-K criteria for initial admissions, re-admissions and re-determinations. Be sure you provide supporting documentation for all criterions you check.)

- **Block "A". Admission of a potent and dangerous injectable medication and solutions on a daily basis or administration of routine oral medications, eye drops or ointment**. ***(Cannot be counted as a second criterion if used with criterion K-7***). The medications must be listed in the "Medication Prescribed" section of this form.

  All medications listed need to have a supporting diagnosis to go with it. Medications taken over the counter such as "Aspirin", can apply to this criteria, if the doctor has prescribed them to be taken every day. **ALL "attached" medication lists MUST have the clients Name, Medicaid Number and the Date printed on the attachment.**

  Daily is 7 times per week. Routine is less than daily but on a regular and continuing schedule. (Example: B12 injections monthly)

  As needed (PRN) will not support this criterion.

  G Tube administration will not support this criterion.

  Medications are entered into AIMS by the Case Managers. There are many helpful Internet sites that can be used to find medication names. **Do not guess!** If you can not read the medication name, call the physicians office for the correct spelling or call the nurse at ADSS doing the level of care determination for assistance. The medications are used by the reviewing nurse to make the medical determination.

- **Block "B". Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of clients who are determined to have restorative potential and can benefit from the training on a daily basis per the physician's orders**. Examples include: speech, physical and respiratory therapy on a daily basis. Supporting information is required on the care plan under non-waiver services, such as, who is providing therapy, how often and the date of the last assessment.

  The patient needs to be receiving therapy at least 3 times per week in the community setting to support this criterion.

  Therapy by a family member must be supported by who is following the therapy and it must be monitored by a professional. (HH, MD etc.)

  This criterion requires a diagnosis to support need. (Example: CVA…PT to improve gait)

  Range of Motion (ROM) will not support this criterion.

  Remember: restorative nursing can not continue for months or years without being reassessed.

- **Block "C". Nasopharyngeal aspiration required for the maintenance of a clear airway.** This is used for anyone that is getting suctioned to keep their airway clear. The patient will need a medical diagnosis to support the need for suctioning. (Example: Closed head trauma.)

  Frequency and who provides the suction should be listed under the non-waiver services section on the care plan.

- **Block "D. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created. *(Cannot be counted as a second criterion if used in conjunction with criterion K-3 if the ONLY stoma (opening) is a G or PEG tube. Cannot be counted as a second criterion if used in conjunction with criterion K-4 if used for colostomy and ileostomy.)***

  This criterion is checked for anyone with a "G-Tube" for feeding or any other tube that may be in place in the clients' body except an urination tube with a bag (Foley catheter) that a nurse comes to check and change frequently. A Foley catheter will not support this criterion.

  The comment section or additional diagnosis (medical form) should indicate the type of tube the patient is using.

Non-waivered services on the care plan should indicate who provides care and what care is provided. (Example: G Tube/Peg Tube, medication administration and flushed TID)

- **Block "E". Administration of tube feedings by naso-gastric tube.** This is VERY RARE. It is a tube in the nose; most people do not have this at home.

- **Block "F". Care of extensive decubitus ulcers or other widespread skin disorders.** Please put in the comments section what type of skin disorder the client has. If it is a Decubitus ulcer (bedsore), on the care plan under non-waivered services, indicate the stage of wound, where the wound is, who is providing wound care and how often someone is taking care of it.

- **Block "G". Observation of unstable medical conditions required on a regular and continuing basis that only can be provided by or under the direction of a registered nurse. (*Cannot be counted as a second criterion if used in conjunction with criterion K-9*).** This can also be provided by the clients' physician. State what the unstable medical conditions are (if they are not obvious), who provides the observation and how often (regular and continuing basis is defined as no less than every 3 months) (Foley catheter).

- **Block "H". Use of oxygen on a regular or continuing basis.** Please put in the comments section when the client is using the Oxygen. The client must be using the Oxygen REGULARLY **or** CONTINUALLY. Regular can be at night only or day only; however, PRN is not regular and continuing.

- **Block "I". Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, postoperative, or chronic conditions per physicians orders.** Indicate who is doing the dressing changes and how often.

- **Block "J". Comatose client receiving routine medical treatment**. If the client is non-responsive at all times to people, place or surroundings, this is the correct criteria.

- **Block "K". Assistance with at least one of the activities of daily living below on an ongoing basis: *(Check all boxes below that apply. See additional information concerning criterion K below.)***

  (Criterion K should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance. Multiple items being met under (K) will still count as one criterion.)

1. **Transfer- The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis *(daily or two or more times per week).***

2. **Mobility- The individual requires physical assistance from another person for mobility on an ongoing basis *(daily or two or more times per week).* Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane or other mobility aid shall not by itself be considered to meet this requirement.**

3. **Eating – The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement. *(Cannot be counted as a second criterion if used in conjunction with criterion D if the ONLY stoma (opening) is a G or PEG tube.)***

4. **Toileting – The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care or indwelling catheter care on an ongoing basis *(daily or two or more times per week). (Cannot be counted as a second criterion if used in conjunction with criterion D if used for colostomy and ileostomy.)***

5. **Expressive and Receptive Communication – The individual is incapable of reliably communicating basic needs and wants *(e.g., need for assistance with toileting; presence of pain)* using verbal or written language: or the individual is incapable of understanding and following very simple instructions and commands *(e.g., how to perform of complete basic activities of daily living such as dressing or bathing)* without continual staff intervention.**

6. **Orientation – The individual is disoriented to person *(e.g., fails to remember own name or recognize immediate family members)* or is disoriented to place *(e.g., does not know residence is a Nursing Facility).***

7. **Medication Administration – The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes but not limited to, reminding when to take medications, encouragement to take reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose. (*Cannot be counted as a second criterion if used in conjunction with criterion A).***

8. **Behavior – The individual requires persistent staff intervention due to an established and persistent pattern of dementia- related behavioral problems *(e.g., aggressive physical behavior, disrobing or repetitive elopement attempts)*.**

9. **Skilled Nursing or Rehabilitative Services – the individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration or intensity than for practical purposes would be provided through a daily home health visit. (*Cannot be counted as a second criterion if used in conjunction with criterion G).***

Frequent Problems Noted with Assessments:

1.) Care plan not reflecting ALL assistance and services.
2.) Supporting documentation for criterions checked is missing.
3.) "F" is checked without supporting documentation to describe the ulcer.
4.) Criterion "B" is checked, but the patient is not receiving it 3xwk as is necessary to meet standards.
5.) The comments section, in general, needs to be more descriptive of exactly why a patient is at risk of institutionalization.

APPROVAL NOTIFICATION

AIMS-2

This is verification that waiver services have been approved.

DENIAL LETTER

Notice of Admission Denial

If a denial is made by ADSS, ADSS will issue a denial letter. If a denial is made by AMA, AMA will issue a denial letter. The denial letter shall be retained in the client's case file.

CASE MANAGEMENT FORMS

Case Management Verification
MW-11A and MW-11B or MW-1

Medicaid requires verification of the monthly face-to-face contact. The client's signature and date are used to document delivery of case management services. This form is to be signed and dated by the client/caregiver at the time of the visit and **must** be retained in the case file.

(Case management verification may now be done via *Case Management Verification* form MW-1)

Service Provider Authorization
MW-13A, 13B, 13C & 13D.

These forms are used to specify the scope of services to be provided by the direct service providers (DSP's). The following must be strictly adhered to:

- The services listed on these forms **must** mirror those listed on the Care Plan and in the narrative.
- The case manager **must** be sure each client has a copy of the applicable form(s) placed in the client's home. The in-home copy(s) **will not** contain the client's social security number, Medicaid number, prescription information or diagnoses. Should the worker need to know that information, it is available at the DSP's office.
- In the event the in-home forms are lost or misplaced, it is the responsibility of the **case manager** to replace them. They **must** be in place for auditing purposes. Each client shall have their own individual file. Spouses **shall not** share a common file.
- The case manager **will** ensure that the forms are complete, current, signed/initialed and dated as required.
- These forms are to be reviewed with the client/caregiver at **each** initial assessment, redetermination, Care Plan change and as otherwise needed.
- The case manager **is** to conduct a meeting (introductory visit) with the direct service provider worker, his/her supervisor and the client/caregiver at initial assessment, when there is a change in worker and on an as needed basis.
- The case manager will discuss the assigned tasks with the client/caregiver and the worker and document as required in the narrative.

SIGNATURES

The client should sign his/her name on all required documents/forms for waiver services, if at all possible. If the client cannot sign his/her name, an "**X**" or mark is legal. The mark or "X" must be witnessed. The person witnessing the mark must sign as below. If the client cannot make an "**X**" or mark, the person signing for the client should be the primary caregiver, if possible, or family member. A legal format for signing with an "**X**" or mark is:

her
Sarah **X** Smith Witnessed by _____
mark

- ✓ The *Case Management Verification* form (E&D-11A or E&D-11B) **must** be an original and **must** be kept in the client's case file. The *Case Management Home Visit* tool (MW-1) may also be used to record proof of the case manager visit.

  (Under no circumstances may the clients signature be cut out and taped/pasted to the verification form)

- ✓ It **must** contain original signatures of the client/caregiver.

- ✓ The case manager **must not** sign for the client/caregiver **under any circumstances**.

- ✓ The service provider/worker **must not** sign for the client/caregiver **under any circumstances**.

- ✓ A minor **cannot** sign for the client or themselves.

  (In Alabama, you are a minor if you're under 19 and single. If you're 18 and married or a widow/widower you are no longer a minor)

- ✓ The case manager or worker **can** witness the client's mark or "X".

- ✓ Parents signing for minor children **must** sign "Billy Smith signed by Sarah Smith".

- ✓ Caregivers/family members **must** sign "Mary Smith signed by Sarah Smith".

- ✓ **Document** why the client did not sign for themselves.

- ✓ The client/caregiver signature and date **must** be in the same ink, indicating they were signed at the same time. **Blue** ink is preferred.

- ✓ Signature stamps may **not** be used by the client, caregiver, case manager or DSP (to include workers and supervisors).

- ✓ There **should not** be multiple persons signing for the client, unless there are multiple caregivers in the home and they are listed on page 1 of the assessment and documented in the narrative.

ELECTRONIC SIGNATURES

With the introduction of the Tablet PC, we strongly encourage the use of electronic signatures where possible. This should reduce the stress on the client and make it easier to fulfill this requirement. As we add more MW forms to the data base, more electronic signatures will be replacing the old hard copy signatures on paper. Be sure that you get the "MW-27 Signature Card" form signed. It must be on file to utilize the electronic format for signatures. Be sure to follow the instructions on this form.

If the client is unable sign, they must have a caregiver, with documented Power of Attorney, sign for them. If this requirement is not met, a client **must** use the" ink pen on paper" type of signatures.

(Parents signing for their child is an exception to this rule.)

(All services provided during a month that does not contain proper signatures on the verification form are <u>recoupable</u> by ADSS/AMA/CMS.

<u>60-DAY REVIEWS</u>

Supervision of Personal Care Workers (PCW) by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) shall be conducted at a minimum of every 60 days on-site (client's place of residence) for each client. The supervisory visits **<u>must</u>** be documented in the individual client record and reported to the AAA/COG/RPC. If a 60 day supervisory visit report is late/missing, the case manager **<u>must</u>** provide documentation indicating they are aware of the problem and what they are doing to try to resolve it. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicions of substandard performances by the PCW.

Additional information about sixty (60) day review and other nursing supervision requirements can be found in the "Scope of Services".

<u>INITIAL AUTHORIZATION OF WAIVER SERVICES</u>

The authorization of waiver services is based on the plan of care. The case manager will issue a written Service Provider Authorization Form (MW-13) to a direct service provider to initiate a waiver service. A Service Provider Authorization (SPA) Form should be:

- ✓ Reviewed with the client/caregiver;
- ✓ Specific and accurate including the number of units per visit and the number of days per week that the services are to be provided;
- ✓ Specify if the client is high risk by marking the appropriate block on the SPA form and inform the direct service provider of such;
- ✓ Updated when there is a change in services and each re-determination period;

- ✓ Signed/initialed and dated and;

- ✓ An original kept in the client's case file with a copy placed in the home of the client to be used by the client/caregiver, the direct service provider, Medicaid Quality Assurance (QA) Staff and ADSS QA staff.

- ✓ The case manager should have services in place ASAP; within a week is optimal, anything over 2 weeks needs written justification via the narratives.

MONITORING

Monitoring is a process through which the case manager maintains ongoing contact with the client, his/her family, and the providers of service in order to insure that the services are appropriate and meeting the individuals client's needs. Monitoring also allows an evaluation of the client's condition to determine any changes, which would require modification of the care plan, re-assessment or case discharge.

Case managers are expected to:

- ✓ Perform at least one (1) monthly face-to-face visit with the client. **The visits should begin early in the month** allowing enough time to finish all visits before the last week of the month. This will allow the case manager the last week of the month to catch up on documentation and any make-up visits. **Any and all services provided during a month without a face-to-face is recoupable.**

- ✓ Monitor continuously the services provided to their clients to ensure that appointments are kept and that services are appropriate, effective and provided in a timely manner and according to CMS guidelines.

- ✓ The case manager shall walk through (inspect) the home during the face to face visit to ensure that services are provided as ordered and that there are no health and safety issues present. This includes checking the items listed on the *Case Management Home Visit* tool (MW-1) and the services/tasks listed per the *Service Provider Authorization* form (MW-13). (This includes the areas the client has access to and the tasks the worker is responsible for.) The case manager must document any deviation from this requirement.

- ✓ Instruct the client/caregiver to notify the case manager, not the provider, if services are not initiated as planned, or if the client's condition changes.

- ✓ Promptly identify and implement needed changes on the plan of care. For this reason, some client's may require more frequent monitoring.

RE-ASSESSMENT

Re-assessment is the process whereby client status, function and outcomes are reviewed according to an established timeframe. Re-assessments must be done on all transferred clients; this includes clients transitioned from the nursing home back into the community. The reassessment must be completed and services started within 10 days of the nursing home discharge notification date to the case manager. The client is *reinstated* to the program (refer to nursing home reinstatement policy).

The re-assessment may involve a repeat of all activities performed at the initial assessment or a formal review of the status of the client and the services being provided. Reassessments fulfill the dual purpose of ascertaining the continuing eligibility of the client as well as evaluating the effectiveness of the services.

The most suitable approach to re-assessing services is to evaluate the extent goals have been reached. If each goal has been accomplished, then terminating services or establishing higher goals may be appropriate. If goals have not been achieved, a determination is needed as to whether the goals or services should be modified. In many cases the case manager will decide that the goals and the services are still proper and no change in the care plan is needed.

TERMINATION

Termination is the closure of services. A case may be closed because:

- ✓ Services are no longer appropriate. The client's situation may have improved either physically or by the addition of outside resources.

If a case is closed, the case manager should:

- ✓ Notify the client in advance of the action taken.

- ✓ Inform each client of his/her right to be re-admitted to the program and if care is desired again, the case manager will reopen the case.

The final step in closing a case is to complete all documentation relating to the cause for the action by:

- ✓ Notifying the service providers in writing of the status of the case.

- ✓ Complete agency paperwork to place the case in terminated status.

If a client is deceased, requests to be terminated from the program or looses financial eligibility; a ten (10) day notice of termination is **not** required to be given to the client/caregiver. If a client is terminated for reasons other than those listed above, a 10-day notice is required to be given along with appellate rights and procedures.

MAINTENANCE OF CASES

THE CASE RECORD

Because of quality control investigation under taken by ADSS, AMA and CMS, it is vital that case manager's document:

- The client's medical and financial eligibility
- The appropriateness of the care provided
- Verification that all services billed to Medicaid are reimbursable

CASE NARATIVE

The case narrative shall, with the inclusion of the *Case Management Home Visit* tool (MW-1), **stand alone**. Other items such as *Supervisory or Missed Visit* reports are to be placed in their own sections within the case file.

The case narrative is a written history of contacts with clients/caregivers and other significant people. The history is used to determine a client's initial and continuing eligibility. It is also the primary documentation of case management time for auditing purposes. To remain in compliance with policies and procedures set forth by the Alabama Medicaid Agency (AMA), a face-to-face contact visit must occur each month and as needed with the client. Entries in the case narrative serve to corroborate the signed verification and case mangers time spent on a case. It is mandatory that the dates on both accounts agree.

The *Case Management Home Visit* tool (MW-1) and written narratives shall combine to provide the following:

A brief statement or listing of the activities performed, including:

- Face to Face Visits (monthly and as needed)
- Medicaid Eligibility (monthly and as needed)
- Service Provider Billing is complete and verified as accurate (monthly)
- CM Signature/Initials (hand written in ink after each narrative entry. *CM can type their name and initial in ink or sign name in ink*)
- Information on all services received, both waiver and non-waiver (monthly and as needed)
- Health and Safety of the client (monthly)

If there is a safety issue noted, what was done to correct it? What was done to educate the client/family to help prevent injuries?

- Client/caregiver satisfaction of service (monthly)
- Benefits and Outcomes of services (monthly)

  Example: homemaker services help to maintain a clean and sanitary environment and help delay/prevent client from being placed in a LTC facility. Each service should be addressed.

- Clients needs are being met (monthly)
- Client/Caregiver informed of available sources of support (as needed)

  Is the client aware of other services or agencies that can be utilized to help maintain them in the home? Example: travel vouchers are available from AMA to assist with the cost of transportation to medical appointments.

- Freedom of choice (Initial and as needed)
- Breaks in service, Example: Hospital discharge or admission, out of town visit, short term loss of eligibility. (as needed)
- Supervisory Visits (every 60 days and as needed)
- Follow-up to problems (as needed)
- Missed/attempted visits by case manager (as needed)
- Missed/attempted visits by the service providers (as needed)
- Plan of Care is discussed with the Client/Caregiver (as needed)
- SPA is discussed with the Client/Caregiver (as needed)
- 10 day Notice of Action MW-30 (as needed)
- Case Review and Fair Hearing Instructions E&D-6R (Initial and as needed)
- The client/caregiver is given the complaint/grievance policy and procedures (initial assessment, redeterminations and as needed).
- The client /caregiver are given their rights and responsibilities (initial assessment, redeterminations and as needed).

- A summary of the 12 month (redetermination) review (annually)

CHANGES IN SERVICES WITHIN AN AUTHORIZATION PERIOD

Services may be initiated or changed at any time within an authorization period to accommodate a client's changing needs. Any permanent change in waiver services necessitates a revision of the plan of care. The revised care plan must coincide with the narrative and the case manager must prepare a new Service Provider Authorization form (MW-13).

TEMPORARY CHANGES

All variations in the amounts of services actually delivered as compared to the plan of care (POC) will be explained in the narratives. The case manager should be immediately informed of any changes in services due to illness of workers, illness of clients, absence of workers, absence of clients, or other unpredictable incidences. However, it is recognized that often no discrepancy is discovered until the billing has been received. At that point the case manager has the responsibility of obtaining an explanation for the variation and recording the reason in the narrative. **Be sure to complete a new SPA and narrative entry. A new care plan is optional.**

PERMANENT CHANGES

Any increase or decrease to services added to the plan of care must be clearly explained in the narrative. Each change should relate to a documentable modification in the client's physical or environmental condition. Change based solely at the request of the client/caregiver is not sanctioned.

PROPER FORM COMPLETION

- **Nothing** is to bypass the ADSS office without prior approval.
- White out is **not** acceptable.
- Be sure **all** paperwork is complete with **original** signatures…**not** copies.

TIMELINESS

Applications must be submitted via AIMS timely. To allow for any processing delays, ADSS requires that redetermination applications be transmitted **no later** than the 15th day of the month that it is due and will accept applications as early as 45 days before the eligibility ending date. ADSS **cannot** guarantee that untimely application transmissions will be processed before the end of the month. Failure to submit applications timely could result in a client losing program eligibility. Repetitive incidence of late applications is considered to be unacceptable case management.

REDETERMINATIONS

Waiver services are approved on a twelve (12) month basis. Before this eligibility period expires, it is necessary to redetermine the client's eligibility and the need for services to be continued. The case manager also has the option of performing a reassessment at anytime he/she feels new information warrants it. The redetermination process follows the same procedure as a new application. Due to the frequent delays in gathering information for the completion of the redetermination packet, particularly from the client's physicians, it is strongly recommended that the case manager begin the process at least two (2) months before the case is due to expire. In most cases, a medical form signed by the physician up to ninety (90) days prior to eligibility expiration is acceptable.

When the caseload of a case manager accumulates to an unmanageable amount of redeterminations in a particular month, some of the cases (see below*) can be submitted ahead of time to stagger the scheduling.

* Changing a redetermination date necessitates prior approval. The MSIQ field also has to be changed manually by someone at AMA. AMA will ask for the reason for the change, and it has to be a **true** hardship. AMA will not change the redetermination date for reasons such as "case manager going on vacation". AMA already allows the CM to submit a redetermination up to 45 days early to cover such things.

READMISSIONS

A case that has terminated can be reopened by submitting a readmission application to include a new medical form. All procedures of a new application apply except the ADSS HCBS should indicate "Readmission" rather than "New Admission". Please indicate in the comments section that the client had been on the program before and why they were terminated in the past to include specific dates. A client has to be readmitted regardless of whether or not AIMS shows an open slot. If you need a slot to readmit a client, call ADSS.

REINSTATEMENTS

A reinstatement is completed when a waiver client, enters a nursing home, is discharged from the nursing home and returns home. Upon admission to the nursing home, the client is discharged from the waiver using an AIMS 2. Upon notification of a nursing home discharge (returning home), a face to face visit is required. It has to be performed within 10 days of that notification. The case manager must conduct a face-to-face visit before services are resumed. As with all initial admissions and re-admissions, when doing a reinstatement the CM should meet at the client's place of residence with the client/caregiver, DSP supervisor and the DSP worker if possible. A new HCBS is completed and submitted to ADSS. It is not necessary to obtain a new Admission and Evaluation Data Form. The *comment section* requires the date the client entered the

nursing home, the date the client was discharged from the nursing home, the date the services resumed, and the ending date of the current re-determination period. Services can resume prior to ADSS approval. If the client is off the waiver for more than 100 days, a reinstatement is no longer possible and a readmission is to be completed. If the client enters the nursing home during the re-determination month, and returns home after the last day of the re-determination month, a readmission is completed.

TRANSFERS

When a client transfers from one county to another within the state within the same waiver no information should be submitted to Medicaid until the redetermination is due.

Because of changes in the new Medicaid MMIS, there is no simple and "clean" way to process waiver-to-waiver transfers or nursing home to waiver transfers that occur in the middle of the month. For this reason, there is a requirement that these transfers are processed for services to begin on the first of the next month. This process will ensure proper payment to the Operating Agencies rendering services to waiver recipients.

The Medicaid District Office (DO) must be notified by the 15th of the month prior to the recipient's transfer to allow the DO worker time to change an existing Program Code on the system to the Program Code for services that will be rendered on the first day of the next month. If the correct Program Code is not on the system by the first of the month, payment cannot be ensured for services rendered.

This does not apply if:

- The recipient is a new award and there is no existing Program Code, or
- The recipient is transferring from a waiver to a nursing home, or
- The recipient is not certified by the Medicaid District Office, so there is no Program Code.

For waiver participants who are not certified by the Medicaid District Office, transfers can occur as soon as practical. For example, waiver participants certified by the Social Security Administration can be transferred anytime during the month when the transfer is coordinated between the transferring AAA and the receiving AAA.

CLIENT MOVES

1. A client moves from one county to another **within the same** AAA/COG/RPC region. **Do not** submit anything to ADSS. Make the appropriate corrections in AIMS such as the correct address and county.

2. A client moves from one county to another county in **a different** AAA/COG/RPC region. (Contact ADSS for instructions regarding procedures for billing.)

TRANSFERING AGENCY:

The transferring agency will submit the original AIMS-2 with transfer information to the receiving AAA/COG/ RPC; this should include the date of transfer, the agency and the county the client is transferring into. A copy of the AIMS-2 must be maintained in the original agency case file. The transferring case manger should go to the AIMS program and look in the "Client Information" tab that belongs to the client to be transferred. Click on the "Agency" folder scroll button and click on the name of the agency the client is being transferred to. **Be sure to save your selection**. The original copies of all forms and narratives should remain in the original case file (held by the original agency) with copies sent to the new/receiving agency to facilitate the arrangement of services and a continuity of care. Please DO NOT submit an AIMS-2 to ADSS for processing; this will cause the client to be **terminated** from the program.

RECEIVING AGENCY:

The new/receiving AAA/COG/RPC should immediately contact the client to ascertain if services are still appropriate, in what form, amount and to reflect the current social situation of the client. A new reassessment (HCBS, pages 1, 2 & 4) is then completed and held in the client's case file. **(Do not submit to ADSS)** All noted changes should be indicated on the reassessment such as: change of address, county, phone numbers, etc. It is not necessary for the receiving agency to complete another Medical Form unless the condition of the client has changed sufficiently to warrant an adjustment in the level of care or the client has a new physician. Any changes should be handled on a new Care Plan. The reassessment, including a copy of the Medical Form from the transferring agency will be kept in the client's case file and must be accessible to ADSS, AMA, and CMS for Quality Assurance purposes. This application needs to be marked: "*Reassessment due to transfer" and be dated with the transfer date".*

(If a slot is not available in AIMS at the receiving agency, call ADSS for a manual transfer to be done. ADSS will resolve the slot issues as needed to insure your agency maintains its' assigned slot levels.)

NOTE: All transfers, may occur **only** on the first day of the month. Any exception to this rule **must** be prior approved by ADSS. Any services provided prior to this date or prior to the re-admission date are not reimbursable.

TERMINATION PROCEDURE

(Termination requires prior approval from the Lead Case Manager.)

DEATH, ADMISSION TO A NURSING HOME OR MOVING OUT OF STATE:

Upon notification of death, admission into a nursing home, leaving the state, or other reason for termination, the case manager will submit the original AIMS-2 to ADSS for processing to Medicaid, be sure to indicate the reason for termination. The effective date of termination will be the date of the change in these instances. Always be sure

that termination dates are correct. Once processed, only Medicaid can make a correction and that is per written request by ADSS.

FINANCIAL INELIGIBILITY:

If the case is terminated because of SSI or Sup ineligibility, services will be terminated on the last day of the last month of Medicaid coverage. If the client becomes financial ineligible, and you know that it is a short term problem, DO NOT discharge the client. Place the services on hold, and resume those services after financial eligibility is reestablished. The client may reapply as 300% deeming. DO NOT terminate. Call or email the ADSS nurse reviewer and request a *Waiver Slot Confirmation Form*. Be sure to document all actions in the narratives.

CLIENT REQUEST:

At any time during active status, a client may request that his/her case be closed. It is advisable that the case manager secures a written statement to that effect and document in the case narrative the reason(s) such a decision was made. This policy also applies to a new applicants not yet approved for wavier services.

MEDICAL INELIGIBILITY:

In the event that a client's condition improves to the point that it is the opinion of the case manager that services are no longer required to prevent institutionalization, or the case manager receives information that the client's condition was not accurately represented in the assessment, the case manager should contact the nurse reviewer at ADSS for instructions on how to proceed.

- A case may also be terminated when a client meets the objectives as stated on the Care Plan. Objectives are met, if the client can now be judged to adequately perform the activities specified on the Care Plan or the informal caregiver can meet the client's needs without waiver support.

In such instances, the case manager should:

- Document reasons the case manager believes nursing home care is not imminent without waiver services, giving specific examples of task performance, observations may be made during unscheduled visits.

- Notify client of action. The MW-30 "Notice of Action", and MW-6R "Appeal and Fair Hearing Instructions", must be given to the client/caregiver as notification of action and the right of appeal.

- Make referrals to other more appropriate services when indicated.

Waiver services should always continue from the time the 10 day notice to terminate was given until the expiration of the 10 day period unless:

- Providing services results in a danger to the health and safety of the services provider or Case manager.

- Providing services is against the expressed wishes of the client, responsible party, and/or significant other.

- There is NO willing services provider available.

NON-COOPERATION AS REASON FOR TERMINATION:

Termination for non-cooperation **MUST** be prior approved by ADSS per AMA guidelines.

DEFINITIONS:

Non-cooperative behavior on the part of the client or caregiver can be classified as follows:

- PHYSICAL THREATS - The client or other persons in the home inflicts or gives credible indication of intent to inflict physical harm to the in-home worker or case manager.

- VERBAL ABUSE – The client or other persons in the home inflicts verbal abuse upon the in-home worker or case manager.

- SEXUAL HARASSMENT - The client or other persons in the home inflicts physical or verbal sexual advances on the in-home worker or case manager.

- ABUSE OF SERVICES - The client or other persons in the home abuses the delivery of services by:

    1. Not allowing workers to enter home or repeated refusal to cooperate with providers and/or case managers.

    2. Repeated unscheduled absences from home during service hours unless due to an emergency.

    3. Not allowing workers to perform scheduled duties as indicated on care plan or SPA.

    4. Conduct which adversely impacts the program's ability to ensure service provision or to ensure the client's health, safety and welfare.

- UNREASONABLE CARE ENVIRONMENT - The client or other persons in the

home create an unreasonable care environment that interferes with the delivery of services.

- REFUSAL TO PROVIDE INFORMATION - The client or other persons in the home refuse to sign required forms.

PROCEDURES

All efforts made in working with the client, responsible party, and/or significant other must be fully documented. All instances of behavior that appear to be examples of or precursors to non-cooperation should be clearly detailed in the case narrative.

1. INVESTIGATION - Upon receipt of a report of an incident of non-cooperation, the case manager will obtain statements from the involved parties including the client, the caregiver, and the worker. The process of investigation should be completely recorded in the case record. Whenever the in-home worker is in a position to observe non-cooperative behavior, a statement should be obtained and placed in the record. Whenever the in-home worker is involved in the occurrence, a copy of the contractor's incident report should be obtained and placed in the record. If law enforcement is involved, obtain a copy of the police report. In most cases a report shall also be submitted to ADSS via the current *On Line Incident Reporting System* (as of this writing ODM).

2. NOTIFICATION - Upon verification of non-cooperative behavior, the case manager should meet with the involved parties to try to resolve the matter. If the decision is made to continue services, the meeting should be followed with **notification in writing** identifying the unacceptable behavior, the agreement reached by the parties and the consequences (possible termination) for recurrences. If possible, get the involved parties to sign a statement to indicate an acknowledgement of the outcome of continued inappropriate behavior, and then send copies to the involved. If there is any question as to the ability of the client to understand the behavior or the consequences, a responsible person must also be informed and his/her signature obtained.

   (The above certified letter **MUST** have ADSS approval prior to sending to the client.)

   If the health/safety of the healthcare professional is in question, immediate termination is appropriate. DO NOT place anyone at risk by continuing services. Contact ADSS ASAP for instruction. The ten (10) day *Notice of Action* is waived.

3. FOLLOW-UP - If care provision has continued and a subsequent violation occurs, notification of termination is sent. Cases being terminated require that a MW-30, “Notice of Action” be issued to the client and his/her physician notifying

them that Waiver services are to be terminated, with the following exceptions:

a) A written statement is provided by the client, responsible party, and/or significant other who specify that services are no longer needed or wanted and/or there is an agreement to reduce, suspend, or terminate services.

b) The client has died.

c) The client moved and left no forwarding address and his or her whereabouts are unknown as verified by return of agency mail.

d) The client moves to another county and waiver services are not being provided in that county.

e) The client transfers to another waiver program.

f) The client has transferred to another AAA/COG/RPC and continues to receive services.

g) The client enters a nursing home, hospital, or other facility where services cannot be provided according to policy.

h) The client losses financial eligibility.

i) The client, responsible party, and/or significant other request by telephone that services be reduced, suspended or terminated.

The above is NOT a definitive list. If an unprecedented situation occurs, ADSS should be contacted.

10-DAY NOTICE:

"Appeal and Fair Hearing Instructions" form MW-6R must accompany the 10-day notice.

If a client is classified as non-cooperative, you should not exhaust all providers or workers before a termination is made. The reason for termination needs to be because of the client's action(s), not because of being unable to provide services due to the fact that you have exhausted all of your workers or providers.

HEARING PROCEDURES

The two (2) factors affecting the eligibility, medical and financial conditions, are also the two reasons for a denial or termination of a case. Clients denied or terminated for financial reasons should appeal through Medicaid, since they made that determination.

Clients denied or terminated for medical reasons should appeal through ADSS or Medicaid.

1. REQUEST AN APPEAL

The client has thirty (30) days from the effective date of the action to request an appeal. The client may notify the Alabama Department of Senior Services (ADSS) in writing giving the reason for the dissatisfaction and ask for an appeal. At the appeal meeting, the client will have the opportunity to present additional information in support of their case. The client may present the information or may be represented by a friend, relative, attorney or other spokes person of their choice.

If the client wishes to continue services while the case is in appeal status, a written request must be received by ADSS within ten (**10)** days of the effective date of The Notice of Action. The client should also notify their case manager that they wish to continue services.

If services are continued pending the outcome of the appeal and the decision is not in the client's favor, the Alabama Medicaid Agency may recover from the recipient or sponsor, the costs of all services paid after the initial effective date.

2. REQUEST FOR A FAIR HEARING

The Alabama Medicaid Agency will notify the client of the decision of the appeal. If the client is still dissatisfied, a fair hearing may be requested. A written request for a hearing must be filed within thirty (30) days following the notification of the decision. He/she, his/her legally appointed representative or other authorized person must request the hearing and give a correct mailing address. If the request for the hearing is made by someone other than the client, the client must make a definite statement that he/she has been authorized to do so by the client for whom the hearing is being requested. Information about the hearing will be forwarded and plans will be made for the hearing.

The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy which requires an automatic change adversely affecting some or all recipients.

MEDICAID ELIGIBILITY DIVISION POLICIES AND PROCEDURES IN COMPLIANCE WITH CIVIL RIGHTS ACT OF 1964 AND SECTION 504 OF THE REHABILITATION ACT OF 1973.

STATE OF ALABAMA MEDICAID AGENCY
LTC Division-Project Development
501 DEXTER AVENUE
P. O. BOX 5624
MONTGOMERY, ALABAMA 36103-5624

(The client's slot must be held open until this process is completed.)

SERVICES

AMOUNT OF SERVICES AVAILABLE:

The cost of services can't exceed nursing facility costs. There will be occasions when Medicaid will approve a care plan specifying a high cost of services with the assumption that other cases receiving less services will balance out the expenditures. Emergency situations, such as increased disability of the client or decreased capability of the primary care giver may be justification to allow a temporary increase in services. This period of time should be sufficient to either arrange additional non-waiver resources, allow time for the situation to return to its prior need level, or until nursing home placement occurs. These events should be clearly documented in the narrative of the case record.

The Waiver program is not designed to offer 24-hour care or 40-hour per week care. Such provision would be too costly to warrant approval. In those cases in which the client needs supervision during absences of an employed caregiver, the case manager can arrange for a combination of waiver services, volunteer programs and services paid for by the caregiver. This is also an appropriate case in which to consider adult day health care. If no such arrangements can be made, clients should be referred for nursing home placement rather than waiver recipient status.

SERVICES TO CLIENTS IN HOSPITALS:

A hospitalized client is still considered active and therefore the case management function should be performed in the hospital as long as it relates to discharge planning. The case manager may participate with a social worker for planning. Be sure to document all "face-to-face" visits done in the hospital. Document any telephone conversations with family members or hospital staff to ensure continuity of service provision. This situation often requires additional time and effort of the case manager, but such contact is encouraged.

SERVICES TO CLIENTS IN BOARDING HOMES:

The Alabama Medicaid Agency takes the position that a person who qualifies medically for waiver services actually needs a higher level of care than is provided by a boarding home.

Although Medicaid policy states that waiver services cannot be provided to individuals in a boarding home, they can receive adult day health and case management as long as these services are not provided on the premises of the boarding home.

SERVICES TO CLIENTS IN FOSTER HOMES:

Individuals in foster homes may receive waiver services providing the facility is licensed by a recognized agency (such as DHR). The services provided to the client in a foster home are for the client only, for example: homemaker services to clean only the client's room and not common areas accessed by other residents such as the bathroom or kitchen.

SERVICES TO CLIENTS IN ASSISTED LIVING FACILITIES (ALF):

A client may not receive waiver services while residing in an ALF unless given an exception by AMA. These services should be those that are NOT already provided in the facility, such as PC or Adult Day Health.

SERVICES TO CLIENTS WHO RECEIVE HOSPICE:

Hospice services and waiver services may be provided at the same time, so long as no duplication of service exists. If hospice is billing Medicaid for the services, the client cannot receive services under the waiver program. If hospice is billing Medicare, the client can receive services under the waiver program. A client can be discharged from one program and admitted to another program.

SERVICES TO CLIENTS WITH CONTAGIOUS DISEASE:

Upon receipt of notification of a client with a contagious disease, the case manager must receive confirmation from the physician that the client is contagious and instructions must be obtained by the case manager from the physician concerning any special precautions that need to be taken. The information must be provided to the DSP in order for the agency to decide if they will be able to provide services to the client. If the contractor is unable to provide services, the AAA/COG/ RPC will seek another entity to utilize.

Case managers must contact the nurse reviewer at ADSS upon notification of the presence of a contagious disease. The Alabama Department of Senior Services may waive the face-to-face requirement for both the assessment and the monthly visits when deemed necessary. If the face-to-face requirement is waived, the case manager will develop/modify the care plan via telephone. Documentation in the chart should clearly reflect the reason for modification of routine procedures.

TRANSISTIONAL CASE MANAGEMENT

- Assists in the transition of an individual from medical institution.
- Individual must have resided in nursing facility/hospital for 90 days.
- Physician must provide a statement to support transition.

- Client must make written choice to transition

- May be provided for up to 180 days prior to discharge:
  -Begins with face-to-face to conduct initial assessment.
  -Requires at least three (3) face-to-face visits and monthly contact with client and others in support system.

FIREARMS IN THE HOME

Under no circumstances should the welfare of the client, caregiver, case manager, direct service provider or anyone else be placed at risk due to firearm possession by the client or others in the home. The case manager should discuss this type of situation with his/her supervisor, the direct service provider and/or the ADSS program administrator as deemed necessary. Referral to DHR or even the local law enforcement agency may be advisable depending on the situation. If after failing to resolve a situation with the client/caregiver, the case manager and/or DSP has the freedom to choose to not provide services.

ILLEGAL DRUGS

The case manager should always place the Health and Safety of the client, caregiver, service provider and themselves at the forefront, but when illegal drug activity is present it's even more important to be vigilant. Take no chances. If health or safety is in question, immediate suspension/termination of services may be necessary.

Suspected illegal drug activity must be reported to ADSS, possibly DHR and/or law enforcement. If law enforcement is already on the scene when you arrive for the f*ace to face*, follow law enforcement directives and gather as much information as possible for your report. Contact ADSS for instructions on how to proceed.

BED BUGS

The reemergence of this pest is causing alarm within the community. Here is a link and statement to/from one of the *Centers for Disease Control and Prevention* (CDC) FAQs pages:

http://www.cdc.gov/parasites/bedbugs/faqs.html

"Bed bugs should not be considered as a medical or public health hazard. Bed bugs are not known to spread disease. Bed bugs can be an annoyance because their presence may cause itching and loss of sleep. Sometimes the itching can lead to excessive scratching that can sometimes increase the chance of a secondary skin infection."

If you have a client that lives in an apartment that is infested, get the property manager, housing authority, as well as the Health Department involved. An infestation can be very

difficult to get rid of requiring multiple professional treatments. Pesticide misuse/poisoning can become a more dangerous problem, than the bugs themselves, if the treatment is left in the hands of client/caregiver.

You need to utilize all available resources to combat the problem. We don't expect service providers to provide services in homes that are infested. Refusal or inability to correct the situation may necessitate termination of services due to an "*Unreasonable Care Environment*".

As with any unusual situation you encounter, please feel free contact the ADSS staff to discuss at your convenience.

INSTITUTIONAL DEEMING APPLICATIONS

Some clients are eligible for participation in the waiver program due to meeting the nursing home level of care criteria and 300% of SSI income limits. These clients may qualify through the institutional deeming process. This process disregards a potential wavier client's parental or spousal income. It requires financial approval from the Medicaid District Office as well as medical approval from ADSS.

The case manager, along with the client/caregiver, needs to file out Medicaid Form 204 and the ADSS application, which includes the medical form, filled out by the clients' physician. Obtain supporting financial documents. These forms are then submitted to ADSS for processing.

- If the client is under age 65, copies of the client's medical record (progress notes) must be submitted along with these applications for the medical determination to be made by the physician at Medicaid. (Be sure to request enough progress notes to give a good reflection of the clients' medical condition -usually 6 months or more depending on how often they visit the physician).

- If the client is over age 65 medical forms may be requested on an as needed basis.

- Please submit the original Form 204, the ADSS application, and a copy of the original Medical form to include the medications list.

- Please mail the packet to ADSS as well as submit the electronic application via AIMS. Please indicate in the comments section that the application is for a deeming applicant.

(Form 204 may be attained at your local Medicaid office or online. A very limited supply is available at the ADSS office.)

Once financial approval is obtained, the client must start receiving services in order to maintain financial eligibility. If a client that has been deemed onto the program is terminated, he/she loses all Medicaid benefits.

FREEDOM OF CHOICE

CMS mandates that a client be free to choose the direct service provider (DSP) of his/her choice. Therefore, it is possible for a client in active status to request that his/her case be transferred to another service provider agency. The client may request a different worker to be placed in the home. The client may even request a change of case manager. Freedom of choice needs to be documented in the narrative. It should be offered to the client/caregiver at the initial assessment, reassessments, and whenever a change of service provider is appropriate.

REPORTING ABUSE

Under Alabama law, suspicions of abuse or neglect must be reported to the Department of Human Resources (DHR). Case managers should notify the local DHR office immediately by telephone and follow up in writing. Such an occurrence should be documented in the case record. **Be sure there is documentation of follow-up.**

A report shall also be submitted to ADSS via the current *On Line Incident Reporting System* (as of this writing ODM).

HEALTH AND SAFETY

Everything you do should assist in assuring the health and safety of the client. We are required to ensure that with waiver services, the individual can continue in the community without jeopardizing his/her health and safety. It is the case manager's responsibility to be observant and make necessary changes.

CONFIDENTIALITY

In the process of the assessment and the subsequent case management activities, the case manager will obtain knowledge of the client's personal, financial and medical conditions. It is considered ethical practice of social work to protect the confidentiality of this information.

There are two (2) situations when the release of information is considered justified, in the process of obtaining information to ascertain or continue the eligibility of the client for services or when another agency has asked for information as a condition of delivering services. In both cases, information released should be limited to what is necessary.

Providers entering the home to perform services through this program should be given only the personal and medical information that is judged to be applicable to effective delivery of care.

Any request for information that fall outside of these two examples should be referred to the client. At any time, they may consent to have certain information released and the case manager should abide by their wishes.

At no time, should a case manager state the name, address or any other identifying information to the general public. Case examples cited at professional conferences or in professional literature should carry no identifying information.

All correspondence, both written and verbal, destined for Medicaid, must be routed through ADSS. This policy is necessary to assure consistent interpretations of policies and to provide a tracking mechanism for all applications, terminations and redeterminations.

EMPLOYMENT OF WAIVER RECIPIENTS

According to CMS, employment is permissible by a recipient of waiver services providing wages or salary does not terminate SSI and that the individual continues to meet the level of care requirements. Each individual situation should be carefully evaluated and not automatically terminated. The client does not have to be homebound to be on this program.

As you evaluate each individual situation, please keep in mind that Rehabilitation and Education are not services of the waiver programs. Persons whose main needs are in those areas should be referred to the appropriate agency or organizations.

THE FACE-TO-FACE

A new assessment form is not required for each face-to-face visit, but you should be assessing the clients' condition each time you visit them. Observation is very important!

Things you should look for during the face-to-face are:

- ✓ The overall condition of the home.
- ✓ The condition of the client.
- ✓ If any changes should be made, either direct or indirect.
- ✓ Should any referral be made?
- ✓ Are there any problems with service delivery?

- ✓ Is the service meeting the client's need?

- ✓ Are the client's safety and/or welfare in jeopardy in any way?

All of this information should be recorded. All problems identified must have this follow-up documentation. Note changes made and why.

Case managers must be observant, have good judgment and not be afraid to ask questions. It is important to keep abreast each month. Stay on top of situations, because it is impossible for you to correct a problem if you don't.

If you have a difficult client or caregiver, it is extremely important to be thorough with documentation. Things you may not feel are important at the time, can be very important in a fair hearing or if the client is terminated because of non-compliance. If providers are having difficulty staffing a client because of non-compliance, it is important that they provide you with documentation, especially if they refuse to staff a client.

THE CASE FILE

WHY IS THE CASE FILE SO IMPORTANT?

- In most cases, it is the only picture we see of your client.
- Your supervisor will review it.
- Medicaid may review it.
- CMS may review it.
- ADSS will review it.

THE CASE RECORD SHOULD BE:

- Organized – contain all current information together.
- Organized – in the same manner from file to file.
- Typed – use spell and grammar check.
- Information should be clear and concise – just state facts and pertinent information that support those facts.
- Be careful about repetitive information.
- Do not use generalized statements – state facts.

- The file and narrative/MW-1s should be organized in a continuous/chronological way.

- The file and narrative/MW-1s should start with the referral.

- Case management is a service – the narrative/MW-1s should document all case management activity.

- The Care Plan is an outline, while the narrative is the story. The narrative/MW-1s should support any actions taken or service delivered.

- There should be a summary (monthly) in the narrative and/or MW-1 of all waiver and non-waiver services and why they are appropriate.

- It should be clearly documented (via the narrative and /or MW-1) how the services will assist the client to remain in the community.

- There are special services, like respite, that need an explanation (in the narrative).

- Any problems with service delivery should be explained, such as: service interruption, hospital stay, a visit with a relative or by a relative, and illness or poor service delivery.

- Explain all changes in the Care Plan such as: increase in services, decrease in services, deletion of service, addition of service, change in frequency of service, change of service provider or change in living situation.

- The CM must note the receipt of Supervisory Visits and Missed Visit Reports. (In the narrative)

- Redetermination activity should be reflected (via the narrative and/or MW-1). The word "**Redetermination**" is to be in bold print so it stands out for the auditor.

- If a problem is presented, be sure to **DOCUMENT YOUR FOLLOW-UP.**

- Be sure to address "Freedom of Choice".

- Finally…look at your assessment…have you addressed all issues/problems?

THE NARRATIVE

The following should be addressed in the narrative and/or MW-1:

- Why does the individual need services?

- What is the individual's living arrangement like?
- Who lives in the home?
- Are there any problems, which must be addressed?
- Who is the responsible party?
- Why was this person referred to you?
- List financial information – SSI, SSA, spouse.
- List medical information.
- Document both mental and physical stability.
- Document nutritional needs, medications and activities of daily living.
- Document the functional level and whether the client needs assistance/supervision and how any problems are being addressed.
- Elaborate on dependence issue, transfer, locomotion, dressing, eating, toileting, bathing, continence, communication and memory.
- When documenting information in the narrative regarding the client, please make sure that the client is properly addressed as Mr. Client, Ms. Client…etc.

To sum it up, the case record should give anyone who reads it, a complete picture of your client and their circumstances.

Remember…if it's not documented, it's not done. Keep it current at all times!

ORGANIZATION OF THE E&D WAIVER CASE FILE

(The following is the expected format for the case folder. You do not need to purchase new folders. Separation into sections, as outlined below, with a divider page/tab will suffice.)

First Section

Initial Referral Information
Home-Delivered Meals Assessment and Implementation tool
Home Delivered Meals

Second Section

Service Authorization (SPA)
Care Plan
Case Review & Fair Hearing Instructions
Client Rights & Responsibilities
Complaint/ Grievance Policy & Procedures
Freedom of Choice
Signature Card
Notice of Action (MW-30)
Release of Information (MW-4)

Third Section

HCBS Application (HCBS Program Assessments)
Approval Notification (Aims-2)
Letter to Doctor for Medical Information
Doctor's Letter of permission (For At-Risk Clients)
Deeming Application

Forth Section

Case Management Verifications (if still using a separate MW-11 form)
Direct Service Providers Supervisory Visits
Missed/ Attempted Visits Reports

Fifth Section

Case Narrative
Case Management Home Visit tool (MW-1)

Sixth Section

HIPAA Info
Client Monthly Eligibility (MSIQ & MSEV)
Correspondence/s
Peer Reviews

Please note: *Copies of Complaint Reports, Critical Incident & AMA Surveys keep separate but accessible*.

CLIENT RIGHTS AND RESPONSIBILITIES

RIGHTS:

- ✓ The client has the right to confidentiality concerning his/her personal affairs.

- ✓ The client has the right to be treated with dignity and respect.
- ✓ The client has the right to maintain his/her independence to the degree possible.
- ✓ The client has the right to quality services delivered in a consistent and stable manner.
- ✓ The client has the right to express grievances and to appeal decisions made by agencies.
- ✓ The client has the right to be informed of resources available through the program.
- ✓ The client has the right to be informed of the limitations of the program.
- ✓ The client has the right of “Freedom of Choice”.
- ✓ The client has the right to participate in the development of the Plan of Care.
- ✓ The client has the right to reject services and be informed of the consequences of such actions.

<u>RESPONSIBILITIES:</u>

- ✓ The client and his/her family have the responsibility to cooperate with the case manager and the in-home workers and treat them with respect.
- ✓ The client and his/her family have the responsibility to participate in the provision of care to the greatest extent possible.
- ✓ The client and his/her family have the responsibility to report changes in the client’s situation to the case manager as soon as possible.
- ✓ The client and his/her family have the responsibility to be at home when services are scheduled or to notify the service provider prior to the service date.
- ✓ The client and his/her family have the responsibility to provide adequate food, personal and household supplies so that services may be performed.
- ✓ The client and his/her family have the responsibility to secure proper medical care to the extent possible.
- ✓ The client and his/her family have the responsibility to report inadequate services to the case manager.

- ✓ The client and his/her family have the responsibility to sign verification of services only after ascertaining their accuracy.

APPENDIX I

MEDICAID COUNTY CODES

1. **Autauga**
2. **Baldwin**
3. **Barbour**
4. **Bibb**
5. **Blount**
6. **Bullock**
7. **Butler**
8. **Calhoun**
9. **Chambers**
10. **Cherokee**
11. **Chilton**
12. **Choctaw**
13. **Clarke**
14. **Clay**
15. **Cleburne**
16. **Coffee**
17. **Colbert**
18. **Conecuh**
19. **Coosa**
20. **Covington**
21. **Crenshaw**
22. **Cullman**
23. **Dale**
24. **Dallas**
25. **DeKalb**
26. **Elmore**
27. **Escambia**
28. **Etowah**
29. **Fayette**
30. **Franklin**
31. **Geneva**
32. **Greene**
33. **Hale**
34. **Henry**
35. **Houston**
36. **Jackson**
37. **Jefferson**
38. **Lamar**
39. **Lauderdale**
40. **Lawrence**
41. **Lee**
42. **Limestone**
43. **Lowndes**
44. **Macon**
45. **Madison**
46. **Marengo**
47. **Marion**
48. **Marshall**
49. **Mobile**
50. **Monroe**
51. **Montgomery**
52. **Morgan**
53. **Perry**
54. **Pickens**
55. **Pike**
56. **Randolph**
57. **Russell**
58. **Shelby**
59. **St. Clair**
60. **Sumter**
61. **Talladega**
62. **Tallapoosa**
63. **Tuscaloosa**
64. **Walker**
65. **Washington**
66. **Wilcox**
67. **Winston**